STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910533	R **06/13/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PHILLIPPI CREEK	**5501 SWIFT ROAD SARASOTA, FL 34231**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced revisit survey was conducted on at Brookdale Phillippi Creek, an assisted living facility (license #7102) located in Sarasota, Florida. This was a follow up to complaint survey for CCR # 2017004213 completed on .

The following is a description of the deficiencies.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record reviews, staff interview, and review of medication policies and procedures, the facility failed to ensure the physician and legal representatives were notified of missed doses of medications for 3 (Resident # #8, #9, and #11) of 4 sampled residents.

The findings included:

1. Review of the facility's medication error policy and procedure, revised , revealed that it included the following: "...for incorrect medication...dose...the person assisting with medications...should notify the nurse, Executive Director, District/Regional Nurse or designee immediately...associates re not to give any further medications until instructions are given by the nurse based on the nurse's profession judgment or in consultation with the physician...document the medication administered or omitted...follow the reportable events policy/grid and complete an incident report..."

2. Review of the 1823 health assessment dated showed Resident #8 with a medical history of and .

When reconciling the physician's orders with the and 2017 Medication Observation Record (MOR), the following was noted:

10 mg. ER (Extended Release) q (every) d (day)-missed doses on , , , , , , , through .

Tears-missing 4 p.m. dose on 5/4- ; missing 7 p.m. dose on 5/5- , , 6/1- .

, 10 mg., 5 mg., , 2.5 mg.-missed 7 p.m. dose on , , 6/1- and .

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1 cap in 8 ounces (of fluid)-missed 9 p.m. doses on , 5/9- , 6/1- , and .

Venlaxafine cap 75 mg. ER-missed 12 p.m. doses on , , 6/1- .

1000 mcg.-missed 12 p.m. doses on , , , , and between 6/1- .

100 mg capsule daily for 10 days-started 6/6 and missed 12 p.m., dose for .

The record failed to show the physician or legal representative were notified of the missed doses of medications.

3. Record review showed Resident #9 admitted to facility on with diagnoses including compression area 9-10 and essential .

Review of the 1823 Health Assessment signed by the physician on 11/ documented Resident #9 required assistance with self-administration of medication.

When reconciling the physician's orders with the 2017 MOR, the following was noted:

, 5 mg. 1/2 tab (twice daily)-missed 8 p.m. doses on 6/3- , , 6/8- , , and 8 a.m., dose missed on .

100 mg. daily-8 a.m., dose missed on .

50 mg. 1/2 tab po (by mouth) -missed 5 p.m., doses on 6/3- , , , - and the 8:00 a.m., dose on .

The record failed to show the physician or legal representative were notified of the missing doses of medications.

4. Review of 1823 Health Assessment dated documented Resident #11 admitted to the facility with diagnoses including and . The resident was documented with poor safety awareness.

When reconciling the physician's orders with the 2017 MOR, the following was noted:

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BROOKDALE PHILLIPPI CREEK	**5501 SWIFT ROAD SARASOTA, FL 34231**

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1 tablet po -missed 8 p.m. dose on and .

10 meq ER po -missed 8 p.m., dose on and .

325 mg. 2 tabs by mouth twice daily-missed 8 p.m., dose and .

The record failed to show the physician or legal representative were notified of the missing doses of medications.

No indication responsible party or physician notified of missed doses.

5. In an interview on at 12:10 p.m., the acting Health and Wellness Director (HWD) said she could not find evidence as to why the residents did not receive the medications. She said these would be considered medication errors and an incident report should be completed as well as disciplinary action involving staff. She could not find documented evidence the physicians, nor the legal representatives were notified of the missed doses.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on review of adverse incidents and staff interview, the facility failed to submit 15 day adverse incident reports involving missing medications for 2 (Resident #'s 8 and 9) of 4 residents reviewed and failed to complete adverse incident reports involving an elopement for 1 (Resident #8) of 4 sampled residents.

The findings included:

1. Review of the facility's adverse incident reports showed a one day report dated which documented Resident #8 missing 9 doses of and Resident #9 missing 30 doses of the medication . Law enforcement was notified and interviews with staff were being conducted as part of the investigation.

The facility was asked to provide the 15 day adverse incident report which included the facility's results of the investigation.

During an interview on at 12:30 p.m., the acting Executive Director (ED) admitted there were not 2 separate reports filed, but that a single 1 day adverse incident report was filed for both residents. She

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said there wasn't a 15 day report filed for either resident. She said it must have through the cracks between the time the previous ED left and during her transition to the facility.

2. On , record review revealed the facility was cited for failing to complete an adverse incident report related to the elopement of Resident #8 from the facility, which involved law enforcement. During the follow-up survey on , the ED was asked to provide evidence of a 1 and 15 day adverse incident report.

3. In an interview on at 12:30 p.m., the acting ED said the previous ED did not complete either report and were unavailable for review.

Class III